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ABSTRACT

This paper describes the Home-Based Crisis Intervention (HBCI) program in New York and the characteristics and outcomes of the families involved in a study that investigated the effectiveness of the program. The HBCI program provides short-term intensive in-home services to families with children who are at-risk of out-of-home placements. The intervention focuses on family strengths and needs using a multifaceted approach including skills building, counseling, and the provision of concrete services. The program effectiveness study included 221 children (ages 5-17) experiencing a psychiatric crisis that required immediate intensive intervention, hospitalization, or placement in another restrictive setting. Results indicate 63 percent of the families were Hispanic and 26 percent were African American. Eighty percent of the families had annual incomes of less than $20,000. Only 20 percent of the primary caretakers were employed. Seventy-two percent of the caretakers were single parents, and 55 percent of the caregivers had completed high school. The average age of enrolled children was about 11.5 years. Disruptive behavior and adjustment disorder diagnoses were the most common. After treatment, significant gains were found in cohesion and adaptability from intake to discharge. (CR)

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# Preliminary Family Outcomes of a Field Experiment on Intensive In-Home Interventions for Children in Psychiatric Crisis

Authors

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## Introduction

Every parent, every service provider, and every researcher working in the field of children's mental health shares the common concern that our service system be able to respond quickly and effectively to children who are experiencing a psychiatric crisis. Even as the range of community-based service options has expanded in recent years, and even though there has been an increased commitment to prevent unnecessary hospitalization, there is little research available to help us understand which models of crisis intervention are effective, for whom, and under what circumstances.

In 1987, New York State initiated Home-Based Crisis Intervention (HBCI), modeled on the Homebuilders program developed in Tacoma, Washington (Kinney, Madsen, Fleming, & Haapala, 1977). HBCI provides short-term, intensive, in-home services to families whose children are at risk of out-of-home placement because they are experiencing a psychiatric crisis. Beginning in 1992 with a research and demonstration grant from the National Institute of Mental Health (lR18MHS0357) and the Center for Mental Health Services (SHDSSM50357), a three-year field experiment was conducted to evaluate the effectiveness of HBCI and two additional short-term crisis intervention models, Enhanced Home-Based Crisis Intervention (HBCI+) and Crisis Case Management (CCM). The purpose of the study was to evaluate the family, child, provider, and system outcomes of these three interventions. The study took place in the Bronx, New York, to assess the impact of these interventions with a population that was ethnically diverse and under extreme economic stress.

Each program offered in-home services for four to six weeks, with small caseloads ranging from two to eight families per worker. Workers had flexible schedules and were available by beeper, 24 hours a day, seven days a week. Two of the programs, HBCI and HBCI+, followed

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the Homebuilders model, which employs a cognitive behavioral approach for defusing crises and teaching skills while linking families to a variety of ongoing services. HBCI+ has the added resources of in-home and out-of-home respite care, a parent advocate, a parent support group, flexible service dollars, and additional training on cultural issues as well as on the impact of violence on children. The third program, CCM, is a short-term adaptation of an intensive case management (ICM) program. Workers in CCM carry four crisis cases and four longer-term ICM cases. The focus in CCM is on assessing need, providing concrete services, and linking the client to ongoing services. Families enrolled in CCM also have access to respite care services. More information about the three interventions can be found elsewhere (Evans, Boothroyd, & Armstrong, 1996).

This summary describes the characteristics of the families who were enrolled in the study and reports preliminary findings (aggregated across all three interventions) on family outcomes as measured by: (a) the Family Adaptability and Cohesion Evaluation Scales II (FACES II: Olson, Portner, & Bell, 1982); (b) the Inventory of Socially Supportive Behaviors (ISSB: Barrera & Ainlay, 1983); (c) the Parent/Caregiver Self-Efficacy Scale; and (d) the Parent/Caregiver Satisfaction Survey. The latter two measures were developed by researchers in the Bureau of Evaluation and Services Research of the New York State Office of Mental Health. Another presentation in these proceedings (Evans, Boothroyd, & Holohean, 1996) focuses on child outcomes.

## Method

From November, 1993 through December, 1995, all children who presented at two emergency rooms were screened for eligibility for the study. To be eligible, children had to be between 5 and 17 years of age. Children also had to live in the Bronx in a natural, adoptive or foster home with a caregiver who was willing to participate, and the child had to be able to remain at home safely with intensive services even though they had significant mental health needs. The emergency room psychiatrists and psychiatric social workers conducted the assessments and were instructed to refer only children who would likely be hospitalized in the absence of crisis intervention services.

All eligible children whose parents consented to participate were randomly assigned to one of the three programs. Data were collected at intake, discharge from the intervention, and six months following discharge. The data reported here are preliminary. More in-depth analysis will be conducted when data collection is complete in the fall of 1996. In all, 296 children were referred to the study, 233 were discharged, 38 withdrew from the study prior to discharge, and 25 were hospitalized during the intervention. Descriptive data and satisfaction data are presented for the approximately 221 families discharged as of January 1996. Data concerning changes from intake to follow-up are presented for approximately 115 families for whom six month follow-up data were available.

## Results

The families enrolled in this project were representative of the demographics of the Bronx. Sixty-three percent were Hispanic, and 26% were African American. Eighty percent of the families had annual incomes of less than $20,000, with 53% below $10,000. Only 20% of the primary caretakers were employed. Seventy-two percent of the caretakers were single parents. Fifty-five percent of the primary caregivers had completed high school.

The average age of enrolled children was about 11.5 years, with slightly more children (56%) than adolescents. Disruptive behavior (29%) and adjustment disorder (18%) diagnoses were the most common. Seventy-one percent of the children had at least one functional impairment, and 94% were judged to have behaviors that endangered themselves or others. While the majority of children were in special education (53%), and many had received prior mental health treatment (42%), relatively few had been previously hospitalized (11%).

On FACES II, statistically significant gains were found in both cohesion and adaptability from intake to discharge. The six month follow-up assessments indicate some erosion in these gains, which is statistically significant for the cohesion subscale (see Figure 1).

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A preliminary analysis was conducted to determine if there were any child or family characteristics that might distinguish between families who experienced more positive versus more negative outcomes as measured by FACES II. None of 21 characteristics examined (e.g. age, gender, diagnosis, family composition, maternal education level) were found to be significant.

The Parent/Caregiver Self-Efficacy Scale assesses how comfortable parents feel with their parenting skills and ability to care for their child. Intake to follow-up gains in caregiver self-efficacy are presented for four of the domains assessed (i.e., behavioral management skills, dealing with school-related issues, ability to advocate, and providing emotional support). Of these, only the gains in behavior management and emotional support were statistically significant. There was a statistically significant decline from intake to follow-up in caregivers' feelings of being able to effectively meet the basic needs of their children (see Figure 2).

The ISSB indicated an extremely low level of perceived informal support among all enrolled families (average score = 86 out of a possible score of 200). Preliminary findings suggest that the interventions have little impact here, and that there is actually a decline from discharge to follow-up, which is statistically significant (see Figure 3).

Each child and primary caregiver is asked at discharge to complete a satisfaction questionnaire. Caregivers were particularly satisfied with the counselor or case manager's advice, cultural understanding, and handling of personal issues. Similarly, caregivers were very satisfied with the help they received, their access to the counselor or case manager, and the extent to which their counselor or case manager was well-informed (see Figure 4).

There was a little less satisfaction with the counselor's or case manager's ability to link the family with other services, the quality of skills teaching, the time it took the worker to contact them upon referral from the emergency room, and the overall frequency of contact. Nevertheless, even on these items, the percentage of caregivers who reported that they were very satisfied never fell below 80%.

## Discussion

The results presented in this paper are at first glance a small subset of the data collected during this field study which is still in progress. While the children are the primary subjects of the study, our examination includes an in-depth look at the families who care for and support each of these young persons on a day-to-day basis.

In this preliminary analysis of change on three family/caregiver measures, we have aggregated results across all three interventions. Given the focus of at least two

across all three interventions. Given the focus of at least two of the interventions on family problem solving and communication, it is not surprising to see gains in both dimensions of FACES II from intake to discharge. The erosion in these gains from discharge to follow-up may be related to the fact that, while some families were referred to other community-based services upon discharge, few of these services were as intensive, and most did not focus specifically on maintaining these gains.

As suggested by the extremely low baseline scores on the ISSB, the families enrolled in these interventions are not only grappling with significant stress, but the majority are doing so in isolation. None of the interventions focused specifically on broadening family's networks of support, and in the six weeks from intake to discharge, no significant change was measured. A sense of loss following discharge from an intensive intervention is one possible explanation for the significant decline from intake to follow-up. In future analyses, we will look at this issue more closely to determine if there are differences among the three interventions or differences based on the degree to which families participated in family support and recreational activities. We will also look at whether there is any correlation between the perceived level of informal support and other outcomes.

Clearly, there are many more analyses to be conducted to explore the myriad questions embedded in this study. In designing an analytic plan, we will take a variety of approaches that might include the use of composite measures, the weighting of certain measures based on a rationale associated with the intent of the intervention, and other strategies. While preliminary findings support the hypotheses that children in psychiatric crisis can remain safely at home with intensive in-home services, future analyses will hopefully enable us to comment in more detail about which interventions work best for which children and their families and why.

## References

Barrera, M., & Ainlay, S. L. (1983). The structure of social supports concepts: Measures and models. Journal of Community Psychology, 14, 413-445.

Evans, M. E., Boothroyd, R. A., & Armstrong, M. I. (1996). The development and implementation of an experimental study of the effectiveness of intensive in-home crisis services for children. Manuscript submitted for publication.

Evans, M. E., Boothroyd, R. A., & Holohean, E. J. (1997). Child outcomes of a field experiment on intensive in-home interventions for children in psychiatric crisis. In C. Liberton, K. Kutash, & R. Friedman (Eds.), The 9th Annual Conference Proceedings: A System of Care for Children's Mental Health: Expanding the Research Base. (pp.

225-230). Tampa, FL: University of South Florida, Florida Mental Health Institute, Research and Training Center for Children's Mental Health.

Kinney, J. M., Madsen, B., Fleming, T., & Haapala, D. A. (1977). Homebuilders: Keeping families together. Journal of Consulting and Clinical Psychology, 45, 667-673.

Olson, D. H., Portner, J., & Bell, R. (1982). Family adaptability and cohesion evaluation scales. St Paul, MN: University of Minnesota, Family Social Science.

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Liberton, C., Kutash, K., & Friedman, R. M. (Eds.), (1997). The 9th Annual Research Conference Proceedings, A System of Care for Children's Mental Health: Expanding the Research Base (February 26 - 28, 1996). Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, Research & Training Center for Children's Mental Health.